AMENDED IN ASSEMBLY MAY 16, 2000

AMENDED IN ASSEMBLY JULY 8, 1999

AMENDED IN SENATE MAY 28, 1999

AMENDED IN SENATE MARCH 8, 1999

# SENATE BILL No. 87

**Introduced by Senator Escutia**

December 7, 1998

An act to add Section ~~14005.24~~ *14005.31* to the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 87, as amended, Escutia. Medi-Cal: eligibility ~~of children~~.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

~~This bill would provide that, to the extent permitted by federal law and in accordance with the requirements of the bill, a child under 19 years of age shall be presumptively eligible for medically necessary Medi-Cal services.~~

*Under existing law, one of the bases for eligibility is the receipt of CalWORKs benefits.*

*This bill would provide for a rebuttable presumption of Medi-Cal eligibility for Medi-Cal beneficiaries whose CalWORKs benefits have been terminated. It would also provide for eligibility redetermination procedures governing*

*cases in which the CalWORKs benefits of Medi-Cal beneficiaries have been terminated.*

*Because each county is required to administer Medi-Cal eligibility determination provisions, the bill would constitute a state-mandated local program.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.*

*This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

*The people of the State of California do enact as follows:*

~~SECTION 1. (a) The Legislature finds and declares all of the following:~~

*SECTION 1. Section 14005.31 is added to the Welfare and Institutions Code, to read:*

*14005.31. (a) When aid to a family under Chapter 2 (commencing with Section 11200) is terminated, family members shall be presumed eligible for benefits under this chapter pursuant to Section 14005.30, unless the county has information that clearly demonstrates either of the following:*

*(1) Family members are eligible under this chapter pursuant to other provisions of law.*

*(2) A circumstance exists that requires termination of Medi-Cal eligibility.*

*(b) The presumption of Medi-Cal eligibility provided for in subdivision (a) shall be deemed a redetermination of the Medi-Cal eligibility, unless the presumption is rebutted. Failure to submit a CalWORKs reporting form*

*shall not in itself rebut the presumption of eligibility provided under subdivision (a).*

*(c) When an individual's basis of eligibility for benefits under this chapter changes from the receipt of aid under Chapter 2 (commencing with Section 11200) to any other basis, including that of being presumed eligible in accordance with subdivision (a), there shall not be a period of ineligibility for the receipt of Medi-Cal benefits.*

*(d) The department shall, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, prepare a simple, clear, consumer-friendly notice to be used by the counties, in order to inform beneficiaries eligible in accordance with subdivision (a) that their Medi-Cal benefits will continue. The notice shall include all of the following:*

*(1) Medi-Cal benefits will continue even though aid under Chapter 2 (commencing with Section 11200) has been terminated.*

*(2) The beneficiary shall be required to submit a status report as defined in subdivision (j). The first report shall be due in three months in order for benefits to continue after a period of three months. The notice shall contain the specific date on which the first status report is due. A copy of a status report form shall be included with the notice.*

*(3) A telephone number to call for more information.*

*(e) The department shall adopt a mechanism to distinguish between cases of persons eligible for Medi-Cal benefits under Section 14005.30 pursuant to subdivision (a) and those whose eligibility under that section is due to other reasons. The mechanism shall be adequate to inform managed care plans, in a timely manner, of the fact that a beneficiary's basis for Medi-Cal eligibility has changed to that described in subdivision (a) and about the actions that will be required to be taken, and the timeframes for taking these actions, in order for eligibility to continue beyond the first status report required under paragraph (2) of subdivision (d). This mechanism shall include a method of informing managed care plans, when*

*applicable, that the 30-day period of eligibility provided for in subdivision (h) has commenced.*

*(f) (1) During the first three months in which an individual receives Medi-Cal benefits in accordance with subdivision (a), the county shall undertake outreach efforts to beneficiaries in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information and to encourage timely submission of status reports. In implementing this subdivision, a county may collaborate with community-based organizations, so long as confidentiality is protected.*

*(2) Every contract between the department and a managed care plan shall contain the following requirements:*

*(A) Each plan shall communicate with its enrollees, in writing, via telephone, or through the plan's provider and point-of-service networks, in order to maintain current enrollee contact information and to encourage timely submission of status reports. The duty to encourage timely submission of status reports shall include contacting beneficiaries both prior to the date when a report is due and upon notification by the department that the 30-day period of eligibility subsequent to the failure to submit a timely or completed status report, as provided for in subdivision (h), has commenced.*

*(B) Each plan shall also share updated information with the county on a monthly basis.*

*(3) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant to paragraph (2) into the beneficiary's Medi-Cal case file and into all systems used to inform beneficiaries of their enrollee status, unless there is reason to believe the contact information received is not accurate.*

*(g) Unless immigration status has changed, a beneficiary eligible in accordance with subdivision (a) shall not be required to supply any documentation with his or her status reports. This subdivision shall not, however, affect the authority of the department to verify*

*eligibility through other means or to request documentation if the county has facts clearly conflicting with information provided in the status report. The department may conduct random sampling of eligibility.*

*(h) (1) If a beneficiary eligible in accordance with subdivision (a) fails to provide the status report at the end of the first three months as required under paragraph (2) of subdivision (d), or the report is incomplete, the beneficiary shall remain eligible for a period of 30 days, during which his or her eligibility shall be redetermined. If the beneficiary submits a completed status report within this 30-day period, it shall be deemed to have been submitted in a timely manner for purposes of determining eligibility.*

*(2) (A) A county shall, during the 30-day period of eligibility provided for in paragraph (1), make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility. Sources for these eligibility redetermination efforts shall, whenever feasible, include, but are not limited to, an open or recently closed Medi-Cal, CalWORKs, or Food Stamp program case file of the beneficiary or of any of his or her family members, and the 'New Hires Registry' compiled by the Employment Development Department.*

*(B) If a county cannot obtain information necessary to redetermine eligibility pursuant to subparagraph (A), the county shall, either directly or in collaboration with community-based organizations so long as confidentiality is protected, attempt to reach beneficiaries, during times which shall include evenings and weekends, in order to obtain this information.*

*(C) If a county's efforts pursuant to subparagraphs (A) and (B) to obtain the information necessary to redetermine eligibility have failed, the county shall send a blank quarterly report form to a beneficiary who did not return the form and a copy of the incomplete form with the missing information highlighted to a beneficiary who returned an incomplete form. The county shall accompany the forms with a simple, clear,*

*consumer-friendly cover letter developed by the department in consultation with the counties and representatives of consumers, managed care plans, and providers, which shall explain why the status report is necessary, that it is not necessary to be receiving CalWORKs benefits to receive Medi-Cal benefits, and that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. A beneficiary shall have 20 days from the date the form is mailed pursuant to this subparagraph to respond. Failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.*

*(3) If, within 20 days of the date of mailing of a form to the beneficiary pursuant to subparagraph (C) of paragraph (2), a beneficiary does not submit the status report or submits an incomplete report, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed report prior to the end of the 10-day period.*

*(i) (1) When a beneficiary's aid under Chapter 2 (commencing with Section 11200) is terminated, and the county has information clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under this chapter, the beneficiary shall remain eligible for benefits for a period of 30 days, during which his or her eligibility shall be redetermined. If the beneficiary submits a completed status report, as provided under subparagraph (C) of paragraph (2), within this 30-day period, the status report shall be deemed to have been submitted in a timely manner for purposes of determining eligibility.*

*(2) (A) A county shall, during the 30-day period of eligibility provided for in paragraph (1), make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility. Sources for these eligibility redetermination efforts shall, whenever feasible, include, but are not*

*limited to, an open or recently closed Medi-Cal, CalWORKs, or Food Stamp program case file of the beneficiary or of any of his or her family members, and the "New Hires Registry" compiled by the Employment Development Department.*

*(B) If a county cannot obtain information necessary to redetermine eligibility pursuant to subparagraph (A), the county shall, either directly or in collaboration with community-based organizations so long as confidentiality is protected, attempt to reach beneficiaries, during times which shall include evenings and weekends, in order to obtain this information.*

*(C) If a county's efforts pursuant to subparagraphs (A) and (B) to obtain all of the information necessary to redetermine eligibility have failed, the county shall send a status report form to the beneficiary highlighting the missing information. The county shall accompany the form with a simple, clear, consumer-friendly cover letter developed by the department in consultation with the counties and representatives of consumers, managed care plans, and providers, which shall explain why the status report is necessary, that it is not necessary to be receiving CalWORKs benefits to receive Medi-Cal benefits, and that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. A beneficiary shall have 20 days from the date the form is mailed pursuant to this subparagraph to respond. Failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.*

*(3) If, within 20 days of the date of mailing of a form to the beneficiary pursuant to subparagraph (C) of paragraph (2), a beneficiary does not submit the status report or submits an incomplete report, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that termination, unless the beneficiary submits a completed status report prior to the end of the 10-day period.*

*(j) For purposes of this section, "status report" means the reaffirmation of eligibility required to be provided in accordance with Section 14012. The status report form shall contain simple questions that will provide sufficient information to determine whether the beneficiary is eligible for benefits under any Medi-Cal eligibility category.*

*(k) The Legislature finds and declares that the provisions of this section are necessary to meet the federal requirements for continued federal financial participation.*

*SEC. 2. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.*

~~(1) The Medi-Cal program is an important program for providing health care coverage to low-income Californians and currently covers approximately 20.4 percent of California's children.~~

~~(2) In 1997, 18.8 percent of California's children, or 1.85 million children, were uninsured, a rate that is substantially higher than in the rest of the nation.~~

~~(3) Between 1995 and 1997, the percentage of California's children who were uninsured increased. This was due to the fact that Medi-Cal coverage for children declined faster than job-based coverage increased between 1995 and 1997.~~

~~(4) There are currently 824,000 uninsured children who are eligible for Medi-Cal.~~

~~(b) (1) It is therefore the intent of the Legislature, to encourage and assist families in signing up their children for the Medi-Cal program.~~

~~(2) It is also the intent of the Legislature to grant children presumptive eligibility for the Medi-Cal~~

~~program in order to facilitate the provision of services to needy children.~~

~~(3) It is the further intent of the Legislature that families use presumptive eligibility to provide immediate services to their children but that they also complete the Medi-Cal application form in a timely manner so that their children can establish a relationship with a regular doctor and receive ongoing preventive care through regular check-ups.~~

~~SEC. 2. Section 14005.24 is added to the Welfare and Institutions Code, to read:~~

~~14005.24. (a) To the extent permitted by federal law and this section, a child under 19 years of age shall be presumptively eligible for benefits under this chapter.~~

~~(b) A qualified entity, as defined in subdivision (c), may determine that a child under 19 years of age is presumptively eligible for medically necessary services under this chapter, if the qualified entity determines, without verification, that the child's family income does not exceed the amount permitted for Medi-Cal eligibility. When a child has been determined to be presumptively eligible under this subdivision, the child's parent or guardian shall have until the end of the month following the month presumptive eligibility is granted to submit a complete Medi-Cal application. If an application is submitted during this time period, the child's presumptive eligibility shall not be terminated until a final Medi-Cal eligibility determination has been made by the county.~~

~~(c) For purposes of this section, ''qualified entity'' means traditional children's health care providers, including pediatricians and health professionals who deliver services in community health centers.~~

~~(d) A child may be determined eligible under this section no more than once per calendar year.~~

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